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KEYNOTE ADDRESS

National Health Care and the Elderly

Honorable BILL GRADISON (R-OH), U.S. House of Representatives (Excerpts from Address)

It is good of the college to let a layman participate in this program. I am impressed with the scope and importance of the issues that you will be discussing.

In my line of work, we tend to be generalists. In a typical year, we vote on hundreds of different issues. We tend to be more specialized in our committee responsibilities. In my case, I spend most of my time on the areas of tax, trade, budget, Social Security and, of course, health care, especially health care for the elderly. The Medicare program is within the purview of the Ways and Means Health Subcommittee on which I am the ranking member.

A national health care policy. This morning, my thesis is simple. It is that uncertainty will increasingly be the reality of government policy toward health care financing. This will be true not only in direct health issues like Medicare and Medicaid and medical research, but also in such key areas as tax and budget policy that have an important impact on the financing of health care and health research.

In your field, you take an oath to do no harm. In our line of work we don't intentionally try to hurt anyone, but sometimes there are unintended and unexpected effects from some decisions that are made in the hammering out and compromising that is an inherent part of creating public policy.

There is a growing tendency to write new laws almost every year in the health care field, particularly with regard to Medicare. This is because the government is committed to pay for health services that have proven to be more expensive than originally anticipated. Government is trying to figure out what to do about the promises made, now that the bills are coming in. This probably explains some of the clearly irrational decision making processes that we are involved in. I can't recall so many vital health issues on the table at any one time since 20 years ago when Medicare and Medicaid were enacted.

Ideally, as in Dr. Wenger's opening remarks, a national health policy should be developed in a rational and coordinated manner with three goals in mind: quality, access and cost containment. But today all we seem to hear about is cost containment. Short-term budget-oriented decision making is clearly overwhelming the consideration of long-term health policy.

Diagnosis related group (DRG) reimbursement. Today's challenge is to be sensitive to the need to restrain costs while expanding access to quality health care. In that connection, I want to focus on the method of reimbursement now used for hospitals under the DRG system. I don't see the DRGs as a permanent solution to the problems of hospital reimbursement. I see them as better than what we had before, which was cost based, but I consider the DRGs a useful interim step as we move toward a more price-oriented system that is likely to be a capitation system.

It could be one that does not assure present Medicare benefits, but an actuarial equivalent, giving the individual beneficiaries greater choice about what benefits they want. Someone might be willing to pay a larger deductible in exchange, for example, for better catastrophic care. Nonetheless, DRGs are going to be with us for a long time. The question we face from a legislative point of view is how to make necessary midcourse corrections in the DRGs. The DRG system is basically a closed pool of funds; if certain DRGs are out of line, they will be subject to review.

Recently, the Congress passed legislation as part of a budget reconciliation package that made a number of changes in the DRG system. These changes were a part of a piece of legislation called the Comprehensive Omnibus Budget Reconciliation Act. The acronym is COBRA, which many people think is appropriate to what we did to the health community. Perhaps most significant is how long it took to act. This law was to take effect beginning October 1985; it was signed into law in April 1986, halfway through the fiscal year, another example of the uncertainty fostered by our legislative process and, in this case, by disagreement between the Executive and Legislative Branches. However, when the smoke cleared and the bill was signed into law, 51 changes in Medicare alone were included in COBRA, another example of the uncertainty factor and of the need for continuing DRG review to make adjustments.

Some of these adjustments were important. They had to do with the wage indexes that help determine how much money goes to rural versus urban hospitals, the direct and indirect medical education add-on and the role of the Peer Review Organizations (PROs) in reviewing the activities of Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs).

We got into an issue that the Administration did not want us to discuss, the question of disproportionate share hospitals. This concerns how to reimburse institutions that pro-

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vide care to a disproportionate number of low income patients.

A lot of Medicare law was included in this package and we are far from finished making adjustments. The purpose of the bill was to save money, and it saved money in Medicare and other programs. The overall savings from that bill will amount to over a billion and a half dollars in the next fiscal year, with increasing amounts in subsequent fiscal years; the President is recommending changes that would save $4.7 billion in Medicare alone. I personally doubt that large, legislated (and I stress the word legislated) savings will occur in the fiscal 1987 Medicare budget. It is clear that we are close to the end of the road in substantial legislated savings from Medicare. It is important to stress that whatever additional "savings" are effected through legislation will squeeze providers, not beneficiaries.

Legislative versus regulatory changes. As a result of the difficulty the Administration is encountering in gaining Congressional support for further budget savings, they are increasingly turning to regulatory changes to accomplish the same goal. This is difficult, but extremely important, to deal with at the legislative end. One example is the question of how large an increase for the next fiscal year, if any, should be made in the overall pool of funds divided up under the DRGs.

The Secretary of the Department of Health and Human Services has had a lot of leeway in the size of the DRG adjustment. This is important because it has an impact on the financial health of the hospital environments in which you practice. One other factor that bears on this is the Gramm-Rudman-Hollings Act, the Deficit Reduction Act, that was passed in 1985. If it is implemented as written and if the sequestration across the board cuts take place as included in the bill, the Medicare budget will be subject to a 2% decrease each year, beginning in fiscal 1987 and continuing through 1991. That would mean no increase if there was a 2% increase scheduled in the budget; the proposed increase would be wiped out by the Gramm-Rudman-Hollings bill.

There is a major question whether the heart of this bill is constitutional. The chances are that a lower court ruling will be upheld that would strip from the Gramm-Rudman-Hollings bill the automatic sequestration of funds and put us back to the usual procedure of the past 200 years in this country whereby, if Congress wants to make a change, it has to pass a law and get the President to sign it or approve it over his veto.

Nonetheless, the Gramm-Rudman-Hollings bill has major consequences. Two aspects are important in understanding the legislative environment in which we consider health legislation. First, the Gramm-Rudman-Hollings bill is an example of moving toward what I call "mega-bills." We haven't passed a specific health bill in a long time whereby my subcommittee could address the impact of Medicare changes on the elderly. We have passed huge bills, such as the reconciliation bill COBRA and continuing resolutions. Last year, we passed one that covered seven departments in one bill. The massive tax bill, which is front page news, puts on the table the entire corporate and individual income tax provisions at one time.

This tendency to move toward "mega-bills" has many consequences. One is that it gives us an opportunity to legislate in Medicare because we have a vehicle to which we attach our legislation; but it also makes it harder to make an impact on the legislative process (if you are working from the outside), because there are not the discrete or separate bills that are easier to deal with.

The second implication of a Gramm-Rudman-Hollings attitude is that it suggests a consensus within Congress that costs are important and that we have to hold down the deficit and, hopefully, reduce it.

In many areas of government, this will probably result in attempts to shift costs to the private sector. In other words, services that might have been performed in the past by government itself, using government resources, are increasingly likely to be pushed off for someone else to pay.

Potential developments in Medicare legislation. I will give you a few examples of what I anticipate will affect the health field and particularly health care for the elderly.

First, we will try to protect beneficiaries under the Medicare program so they get what they are entitled to. At the same time, we are trying to hold down costs by squeezing both the physicians and the hospitals. That is an indirect way to shift costs. Those of you who have had your charges frozen at the reimbursement rate that was in effect several years ago know that this is not a theoretical concern. I think this pattern will continue.

Another example in the Medicare field is to try to force employers to assume health costs that otherwise would be borne by the government. We have already done this with regard to the working aged. Under recently passed law, Medicare can be the secondary payor for workers aged $\geq$65 years. Unless the elderly workers opt out of employer coverage, their employer's coverage pays first; Medicare is secondary. Obviously, this shifts the burden of costs from government. Another example, included in COBRA, is a provision to require employers to continue to make health insurance available for widows, divorced spouses and spouses of Medicare eligible employees. Although these individuals will be required to pay up to the average cost of their coverage plus 2%, chances are that a degree of adverse selection and other factors will result in additional costs to the employer as a result of that legislation. I think we will see more of that type of legislation in the future.

Currently, our most pressing Medicare issue is capital reimbursement for hospitals. Many hospital administrators are convinced that if the Administration's capital reimbursement plan is implemented, hospitals will be forced to choose between defaulting on their bonds and defaulting on service to their communities. A number of hospitals say they will

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be forced into default because of not receiving sufficient reimbursement to pay for their bonds. Obviously, this is important because it may determine the future of institutions where some of you practice.

From a legislative point of view, we are trying to pass a 1 year moratorium on these proposed regulations. It was the Congressional understanding that reimbursement for capital under Medicare would be accomplished through legislation, not regulation. There is a clear intent to move toward some type of prospectively determined rate system for capital, which represents about 7% of hospital costs, as we have already done for the other 93% under the DRGs for the operating side. Meanwhile, we continue to conduct meetings to find a substantive solution to the problem.

In fairness to the Administration, their goal is to reduce access of hospitals to capital markets. They feel that too much capital has been invested in hospitals and, therefore, that the nation is overbedded. Their clear and stated objective is to reduce the number of hospitals beds; they find no need to test their macroplan to determine the impact on individual institutions. It is our legislative responsibility to try to define that impact.

Another tax-related aspect that may have an impact on funding for medical care, particularly hospitals, is the question of the continued access to tax-exempt bonds. I mention the issue to indicate that many things that don't carry the tag "health" have important implications for health care financing.

As mentioned earlier, we are near the end of the road on legislated Medicare savings. I usually go along with these changes, but I have been radicalized by what I consider to be the overemphasis on costs. As a result, I have joined with others of both parties in both Houses to explore ways to broaden access to health care and to assure that care is quality care.

The best way to describe the present state of federal policy toward access to health care is benign neglect. We know there are problems with uncompensated care under this price-oriented health care system, in which all purchasers of health care try to hold down costs. Many of the states are acting or are considering action to ensure access to health care. The most important long-term development is the study the Department of Health and Human Services is undertaking on catastrophic care, not only acute but also long-term care and for all age groups, not just the elderly.

We continue to get anecdotal information with regard to the possible adverse effect of the DRGs on quality of care. For example, DRGs may encourage premature discharge of sick patients. We do not have any comprehensive analysis that would enable us to find out the condition of patients when they are discharged and what happens to them afterward. Discharging sicker and quicker doesn't give us the whole picture unless we can follow those patients and see what care they receive in a skilled nursing facility or at home and whether that is appropriate and less expensive care than staying in the hospital.

Pending legislation on access to and quality of health care. There are two bills I have joined in sponsoring that deal with the questions of access and quality of health care. The first has to do with quality of care. This is one in which the laboring oar was taken by Senator Heinz of Pennsylvania. Among other things, it would require the Department of Health and Human Services to develop a legislative recommendation to refine the Prospective Payment System for hospitals to better account for variations in severity of illness and case complexity. One of the major remaining weaknesses in the DRGs is this intensity factor, but there is no good data base to quantify this factor. Another provision would put in statutory form a requirement that hospitals give Medicare patients a written statement of rights with regard to hospital and posthospital care soon after admission. This is to prevent hospitals from telling the patient that "your days are up and you have to leave."

Another provision involves the beneficiaries right to appeal a continued stay denial to the Peer Review Organization. Hospital incentive plans that involve payments to physicians for meeting specific length of stay or per case cost targets for individual patients would be prohibited. Another important quality-related proposal is that discharge planning be required as a condition of participation for hospitals.

The other bill concerns access to health care. This bill, cosponsored by Senator Kennedy, among others, tries to shift health care costs to the private sector. There are five elements to this legislation:

First, it would provide extension of employment-provided health insurance coverage for laid-off workers and their dependents.

Second, it would create subsidized health insurance pools to allow people without employment-provided coverage to buy health insurance regardless of their health status.

Third, it would require that states establish a mechanism to fund hospital charity care or develop a plan to provide health insurance to all uninsured residents.

Fourth, it would improve and make more advantageous the present tax treatment of employer-provided health insurance to encourage self-employed individuals to offer health insurance to their employees.

Finally, it would provide for development of methods to lower the cost of health insurance to small businesses. Seventy-five percent of all health uninsured Americans are employed or are dependents of employees. Most of these employed, but uninsured, Americans work for self-employed individuals or small businesses. This is a different problem than if most of the health uninsured were unemployed or on welfare.

A new Biomedical Ethics Board has been created by Congress. We have six members from the House and six from the Senate; I will be one of the members.

Ethical considerations in health care. I was interested in Dr. Wenger's opening comments on ethical considerations involved in health care delivery. Certainly, previous Boards have provided useful recommendations. I am especially hopeful that this new Ethics Board will address questions of access and equitable financing of health care for the population as a whole.

I want to emphasize that we are open to suggestions for new steps. There is no master plan. There is no single overriding national health insurance bill or plan. We are in a pragmatic environment and are searching for answers. Any suggestions you and your organization have will be not only welcomed but extremely valuable.

I want to conclude by saying that it is currently more exciting to be in the health care field as a legislator than a provider. We, who are legislators, and this one in particular, salute you and your organization for the concern for health care you show by participating in this Conference, as well as by delivering, day by day, the best possible health care in your own institutions and in your communities.